DOCUMENT RESUME

ED 172 117 CG 013 560

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TITLE Irrational Beliefs of the Obese.
PUB DATE [78]
NOTE 13p.; Not available in hard copy due to marginal legibility

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS *Behavior Change; *Beliefs; *Body Weight; College Students; Comparative Analysis; *Females; Research Projects; Self Concept; *Self Help Programs; Student Attitudes; Student Behavior
IDENTIFIERS *Irrational Beliefs Test; *Obesity

ABSTRACT

The incidence and extent of irrational beliefs in the obese were investigated as well as subsequent changes in such beliefs as a result of participation in a self-monitored weight control program. Subjects were 53 females who were a minimum of 10 pounds and an average of 32 pounds overweight. The obese sample was administered the Irrational Beliefs Tests and also participated in individual counseling sessions over a nine-week period. The control group consisted of 32 female counselor trainees. Results indicate that: (1) a decline in overall irrationality corresponded with a successful treatment program; (2) obese and non-obese participants did not differ in psychological make-up; (3) obese persons entering the program believed it is easier to avoid than face problems; and (4) after completion of the program, the obese sample declined in anxious overconcern, Scale Six of the Irrational Beliefs Test. (Author/HLM)

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Irrational Beliefs of the Obese

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Irrational Beliefs of the Obese

The Public Health Service considers obesity to be one of the most critical health problems in the United States. Blackburn (1977) has estimated that at least 60,000,000 Americans consider themselves obese and has indicated that although Americans presently spend an estimated billion dollars a year in weight-control efforts, serious and long-term efforts at therapy with the obese have been minimal. A great deal of behaviorally oriented research has been directed toward the treatment of this problem; rationally oriented research has been less readily forthcoming.

According to Stuart and Davis (1972), there is little in the literature to support the contention that the obese and the non-obese differ in their psychological make-up. Such assessments have typically used traditional assessment devices and procedures; a review of the literature produced no such measurements utilizing the Irrational Beliefs Test (Jones, 1969). In this instrument Jones has developed a systemmatic assessment of Ellis's (1962) list of irrational beliefs. In addition to a total irrationality score, the Irrational Beliefs Test (IBT) has ten subscales which correspond to the following irrational beliefs:

> Irrational Belief 1: The idea that it is a dire necessity for an adult human being to be loved and approved by virtually every significant other person in his community.
>
> Irrational Belief 2: The idea that one should be thoroughly competent, adequate, and achieving in all possible respects if one is to consider oneself worthwhile.

Irrational Belief 3: The idea that certain people are bad, wicked or villainous and that they should be severely blamed and punished for their villainy.

Irrational Belief 4: The idea that it is awful and catastrophic when things are not the way one would very much like them to be.

Irrational Belief 5: The idea that human unhappiness is externally caused and that people have little or no ability to control their sorrows and disturbances.

Irrational Belief 6: The idea that if something is or may be dangerous or fearsome one should be terribly concerned about it and should keep dwelling on the possibility of its occuring.

Irrational Belief 7: The idea that it is easier to avoid than to face certain life difficulties and self-responsibilities.

Irrational Belief 8: The idea that one should be dependent on others and needs someone stronger than oneself on whom to rely.

Irrational Belief 9: The idea that one's past history is an all important determiner of one's present behavior and that because something once strongly affected one's life, it should indefinitely have similar effect.

Irrational Belief 10: The idea that there is invariably a right, precise, and perfect solution to human problems and that it is catastrophic if this perfect solution is not found.

The goals of this study were to assess the incidence and extent of these beliefs in the obese and to assess change in such beliefs as a result of participation in a self-monitored behavioral weight control program.

Methodology

Sample

Fifty-three female subjects who were a minimum of 10.0 pounds and and average of 32.0 pounds (range: 10 to 54) overweight were placed on a 1200 caloric food-exchange diet combined with a self-monitored behavior modification program. Over the course of the nine week study subjects contacted counselors for individual therapy sessions an average of 7.11 times.

Additionally a sample of 32 female counselor trainees were assessed in order to generate a comparison group.

Instruments

The Irrational Beliefs Test (Jones, 1969) is a 100 item instrument with ten items per belief with subscales corresponding numerically to the beliefs listed in the Introduction. The forced-choice format provides the respondant with five options: strongly agree, moderately agree, neither agree nor disagree, moderately disagree, and strongly disagree. The stimuli for such responses are statements such as "I often find myself planning what I would do in different dangerous situations" (number 96). Construct validity coefficients range from .85 to .99 for each subscale; test-re-test reliability coefficients range . 68 to .87 for each subscale and is .92 for the overall general score (Jones, 1969).

Procedures

The obese sample was assessed with the IBT during a group meeting at the outset of the project and again at its end; weights were measured individually. Subjects were involved in individual counseling sessions

intended to deal with problems encountered relative to the diet and behavior management; there was no particular effort to include rational therapy.

The comparison group of counselor trainees was assessed during a session of the counseling practicum.

Results

Over the course of the nine week program, subjects lost an average of 11.67 pounds. This compares favorably with other reported studies (Voogt, 1978).

Obese persons entering the program displayed a pattern of beliefs that are summarized in Table 1. Most obvious is the lack of gross deviancy, supporting Stuart and Davis's (1972) assertion that the obese and non-obese do not differ in their psychological make-up. While no gross deviancy exists, some trends may be summarized.

The obese tend to believe that it is easier to avoid than to face difficulties (Scale 7). This may manifest itself in the popularity of 'quick-loss' diets, the use of diet pills and other 'magical' treatments, which more often than not are ineffective or have only short-term effects. Related to this is the belief that unhappiness is externally caused and that people cannot control their disturbances (Scale 5). A third belief which tended to show elevation is that one should be dependent on others and that one needs someone stronger than oneself on whom to rely (Scale 8). These beliefs would seemingly preclude the obese from believing that they can do anything positive in regard to their over-weight condition.

The obese tend to believe that if something is fearsome, they should

worry about its occurring (Scale 6). This may underlie the frequently observed phenomenon of the obese being obsessed with (although not necessarily doing anything about) the idea of losing weight. Also elevated was the belief that one's past history is an all important determiner of one's present behavior and that past influences will continue to control future behavior (Scale 9). This belief is typically manifested as a rationalization that a history of being obese determines that the person will remain obese in the future regardless of any efforts put forth.

These obese subjects also tend to believe they must be thoroughly competent to be worthwhile (Scale 2); it is felt that a case could be made that this culture in a sense equates "thin" with "competent". Another belief which tended to be elevated is that some people are bad and deserve punishment (Scale 3). If the obese believe that they are bad and that their overweight condition is a punishment for that badness, they may have little motivation to lose weight and may even further their obesity in order to assuage their guilt.

Forty subjects completed the nine-week treatment and attended the final group session in which the IBT was again administered. There were no significant differences in IBT pretreatment scores between these forty subjects and the thirteen who are not included in the posttreatment analyses. Matched pairs t-tests revealed significant changes in several beliefs for those who completed treatment; this is summarized in Table 2.

Perhaps most notable is the change in the total IBT score ($p<.05$) indicating a decline in overall irrationality corresponding with a successful treatment program (mean weight loss 11.6 lb.). The decline of

nearly 10 points places the obese sample below the mean established by Jones (1969) but still above the mean of the comparison group of female counselors-in-training.

The greatest change observed ($p<.05$) was in the subscale which measures the belief that if something is dangerous, one should be terribly concerned about it and dwell on the possibility of its occurring (Scale 6). This scale measures anxious overconcern according to Jones (1969), and might also be considered a measure of anticipatory anxiety. Changes were also observed ($p<.05$ for each) in regard to belief that it is awful when things are not the way one would like (Scale 4) and to the belief that one must be thoroughly competent to be worthwhile (Scale 2).

Finally, a change ($p<.10$) in the belief that it is necessary for an adult to be loved by every other person (Scale 1) approached the customary level of statistical significance.

Discussion and Conclusions

Use of the IBT indicated that the obese subjects involved in this study were not greatly different from the general population in terms of their attitudinal characteristics. Some trends, however, were noted. Foremost were beliefs that it is easier to avoid than to face difficulties (Scale 7), that unhappiness is externally caused and individuals therefore cannot control their own disturbances (Scale 5), and that one should be dependent on others. When these beliefs are viewed in composite, they generate a picture of clients who avoid seeking active solutions to their problems, who feel it necessary to rely on others to make changes in their lives and who do not believe that betterment of their condition can result

from their own efforts. These characteristic beliefs would seem to be related to the popularity of the alledged fast and easy diets and other magical cures for obesity. Additionally, it is felt that these beliefs are factors in recidivism if the treatment fails to deal with these beliefs as key issues.

The change in the belief that if something is dangerous or fearsome, one should continually worry about its occurrance (Scale 6) has been discussed as a measure of anticipatory anxiety. Consequently it would be expected that this belief would be elevated at the initiation of such a project and would decline over the course of treatment. Thus, this change may be a reflection of situational variables rather than real therapeutic gain. Further investigation is needed to clarify this point.

The decrease in the degree to which the obese endorse the belief that it is awful when things are not as they would like (Scale 4) is less open to question. Jones (1969) has discussed this scale as a measure of frustration tolerance. Obviously one thing the obese should learn in order to lose weight is to tolerate feelings of hunger. It is felt that the treatment program rather than some change in situational variables is responsible for the change in this belief.

Changes in the beliefs that one must be competent to be worthwhile (Scale 2) and that it is necessary for an adult to be loved by everyone else (Scale 1) can be attributed to the interactions with the counselors involved in the treatment program. That is, positive regard (which would affect Scale 2) and direct, honest feedback (which might affect Scale 1) may be verbal activities that transcend therapeutic modalities.

It should be noted that counseling sessions were not RET sessions and that changes in beliefs were due to behavioral interventions and/or situational changes. It undoubtedly would be preferable if our society did not indoctrinate the obese with beliefs that serve to deter their taking positive steps to modify their condition. However, because this is not likely to change in the near future, the possibility of using RET as one aspect of a comprehensive treatment modality should not be overlooked. It may be that the inclusion of rational-emotive concepts in treatment plans for the obese would produce greater and more rapid effects as well as beliefs consistant with the self-control required to maintain their weight loss after the conclusion of such interventions.

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Table 1. Obese and Normative IBT Scores.

IBT Scale	Group: Obese Pre-Test (n=53)	Counselor Norm (n=32)	Test Norm* (n=216)
1	30.0	26.4	32.4
2	30.8	26.6	30.6
3	29.8	25.7	29.1
4	29.9	27.9	31.9
5	25.9	24.8	24.4
6	31.6	26.7	31.5
7	27.9	25.2	25.6
8	30.6	30.1	31.6
9	27.4	23.0	27.3
10	25.7	25.0	26.0
Total	289.8	261.2	290.5

*from Jones, 1969.

Table 2. Changes in Mean IBT Scores.

IBT Scale	Pre-Test	Post-Test
1	29.4	27.7*
2	30.1	28.5**
3	29.3	29.6
4	29.9	28.4**
5	25.9	24.3
6	31.0	28.9**
7	27.5	27.5
8	30.4	30.0
9	27.4	26.3
10	25.6	25.9
Total	286.4	277.0**

* $P<.10$

** $P<.05$